Board Retreat
10/15/16
Minutes

Attending: Dale Barney, David Beaufait, Scott Berry, Barry Clause, Lori Dacier, Barbara Dolyak, Karen Gray, Tim Jennings, Sean Murphy, Mary Paquette, Curtis Payne, Alice Schori, Mike Samson and Peter Thurber

Absent: John Dow, Gilli Lushkov and Jim Spaulding

Dale Barney welcomed and led introductions

"What does it mean and what is required to be an FQHC?" – Sarah Kemble, MD, MPH

- Scope of Project
    - We will always refer back to this when being assessed
    - Nonprofit Corporation
- Applying for FQHC status
    - Increased reimbursement for Medicare and Medicaid
    - Grant award (although it is getting smaller) still important and we would receive it annually, unrestricted and can incur costs
- Look-a-like status
    - We would receive enhanced rates, but no annual grant
- Need to be in operation for at least 6 months before eligible to apply
- Absolutely need connection with the community, assessors look for this on a compliance level
- Need to review Medicare and Medicaid statutes for FQHC requirements
- 340b – drug pricing system, receive lower pricing for drugs
- National Health Service Corp.
    - Recruit candidates
    - Offer loan reimbursement for medical staff
    - Required to stay for 2 years
- Federal Torte Claim
    - FQHC and Look-a-like deemed federal employees and avoid cost of malpractice insurance
- Scope of Services
    - Service and sites
    - Form 5a – Needs Assessment
        - Some required
        - Some added based on community need
    - Form 5b – Location and hours
        - Access
    - Both 5a and 5b should be Board level decisions
- 3 key components – Scope of Service, Needs Assessment and Financial Plan (can you survive?)
    - Needs Assessment = Scope of Services

        - Cannot turn anyone away
        - Required to meet a "need" no one else is filling, i.e. access barriers, cultural barriers, geographic barriers, linguistic barriers
            - Section 8 housing qualifies as public-housing
            - LGBTQ, HIV, AIDs, Elderly
            - Clinical staff must meet demonstrated needs
            - Staffing must flow from Scope of Services
        - Gather needs assessments from other organizations
- Policy for credentialing and privileges
    - Must redo every 2 years
- Organizational chart must reflect Scope of Services
- Must serve patients of all ages
- Must coordinate care
- Memorandums of Understanding (MOU) needed for cross-coverage
- Must demonstrate patient and community input with regard to hours of operation
- Must have MOU with at least one hospital
- Financial requirements (see handout)
- Management – (check compliance beforehand)
    - Don't over specialize
    - Don't get too administratively top heavy
- WE NEED TO REVIEW OUR STAFFING MODEL
    - Chief Executive Director – Should be our 1st hire
- Key Documents
    - Administrative policies
    - Fiscal policies
    - Clinical policies
    - Articles of Incorporation
    - Bylaws
    - Needs Assessments
    - Scope of Services
- National Association of Community Health Centers
    - Board info – see handout
- Compliance
    - Must comply with federal, state and local laws and regulations
    - Use Bi-state for compliance issues
- All policies must be brought to and approved by the Board of Directors

Revising and Building our Vision and Mission Statements – Pete and Karen (see handouts "Summary of Core Values" and "Vision and Mission"

- Small group breakout
- Full group collaboration
- See attached proposed Vision and Mission Statements

Respectfully submitted by
Lori Dacier, Secretary